Section IX

PRESUMPTIVE ELIGIBILITY VERSUS FULL ENROLLMENT: POPULATIONS PROFILED

The presumptive eligibility process was conceived and adopted as an operational method to rapidly move patients into the care provided under the Alliance program. It complies with the somewhat opposing requirements listed below:

1. Restructuring plan for the PBC, pursuant to the requirements of the Human Support Services title of the District of Columbia Appropriations Act: "the goal of this plan is to provide the volume of medical services currently provided at the PBC to uninsured District residents."
2. Agreement between the District of Columbia Financial Responsibility and Management Assistance Authority and GSCH Corporation I: Exhibit A, 1.0– Target Population (persons will be eligible for the DC Healthcare Alliance program if they meet the following criteria the "Eligible Uninsured:" District of Columbia resident; lacks third-party insurance and family income equal to or below 200 percent of FPL. The contractor shall enroll eligible individuals into the program).
3. Agreement between the District of Columbia Financial Responsibility And Management Assistance Authority and GSCH Corporation I: Exhibit A, 5.0 – Administrative Services, 5.1 – Enrollment and Eligibility.

To ensure each of the above requirements were met, presumptive eligibility status was shaped to provide coverage for thirty- (30)-days. This allowed for care to be provided while the presumed uninsured DC resident was being considered for a full six- (6) month period of coverage.

Presumptive eligibility takes place when the individual verbally attests to the above three (3) criteria for entry into the Alliance but does not have documentation of the requirements. To process the individual and allow for uninterrupted services, he/she is enrolled into the program as "presumptively eligible" for thirty (30) days, or until the individual can produce documentation of the eligibility criteria. The applicant is given status within the system by assignment of an enrollment number and authorization to receive services as evidenced by presenting the "pink" copy of the application.

When the presumptively eligible individual presents full documentation of DC residence, no other form of insurance, and an income of less than 200 percent of FPL, he/she is then fully enrolled into the program for six (6) months. (For purposes of this report, these individuals are referred to as documented enrollees.) However, if verifying documentation is not presented for full enrollment, the presumptively eligible status expires at the end of thirty (30) days from the time that the application is completed.

In theory and practice, the same individual may present multiple times for presumptively eligible status within the Alliance. However, this practice does not seem to be occurring on a large scale:

- During the first year, 37,614 members were enrolled and 10,406 were given presumptively eligible status
- Twenty-eight percent of the Alliance population were enrolled as presumptively eligible for services
- Of the 10,406 presumptive members, 4,615 distinct individuals received one or more services

- The presumptive eligible enrollees' health service utilization rate was 44 percent.

This section provides an overview of the first twelve (12) months of services, and information on the following:

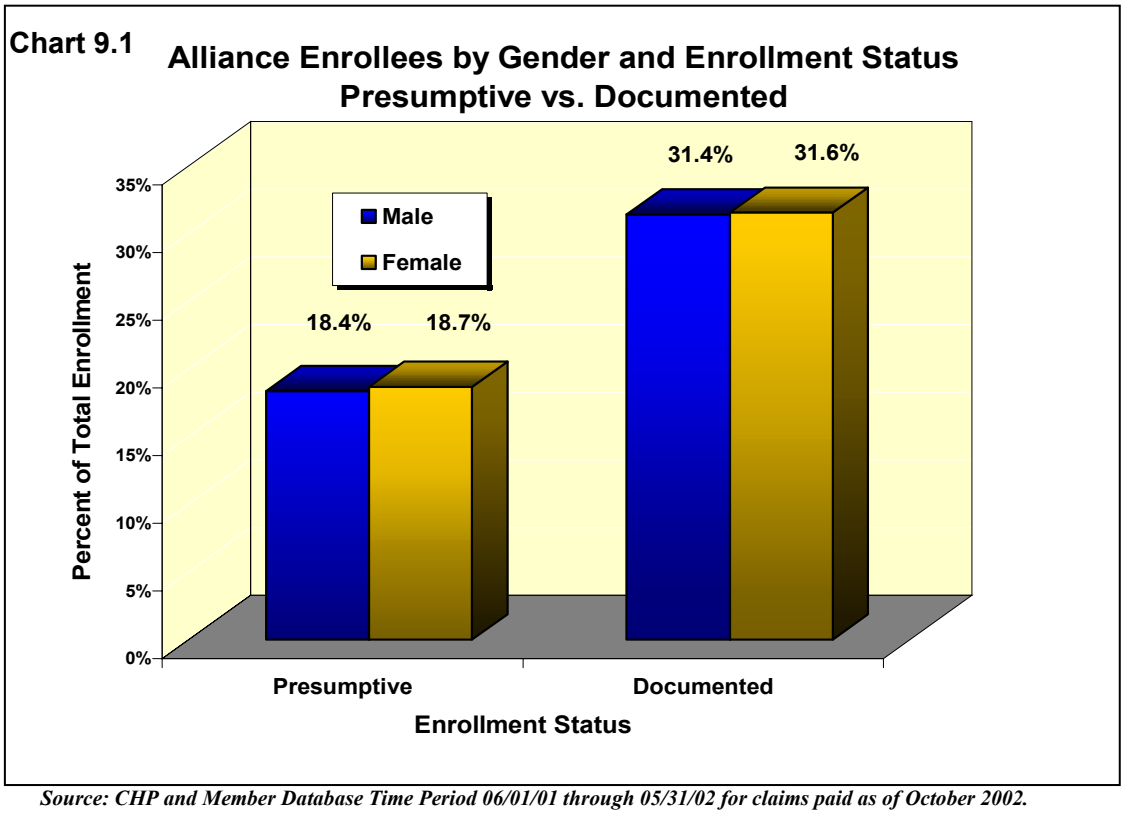
- The population demographics of the presumptively enrolled population
- The disease profile of the presumptively enrolled population
- The health service utilization of the presumptively enrolled
- Recommendations for next steps.

Enrollee Demographics

Comparing the presumptively eligible enrollees to the documented enrollees reveals:

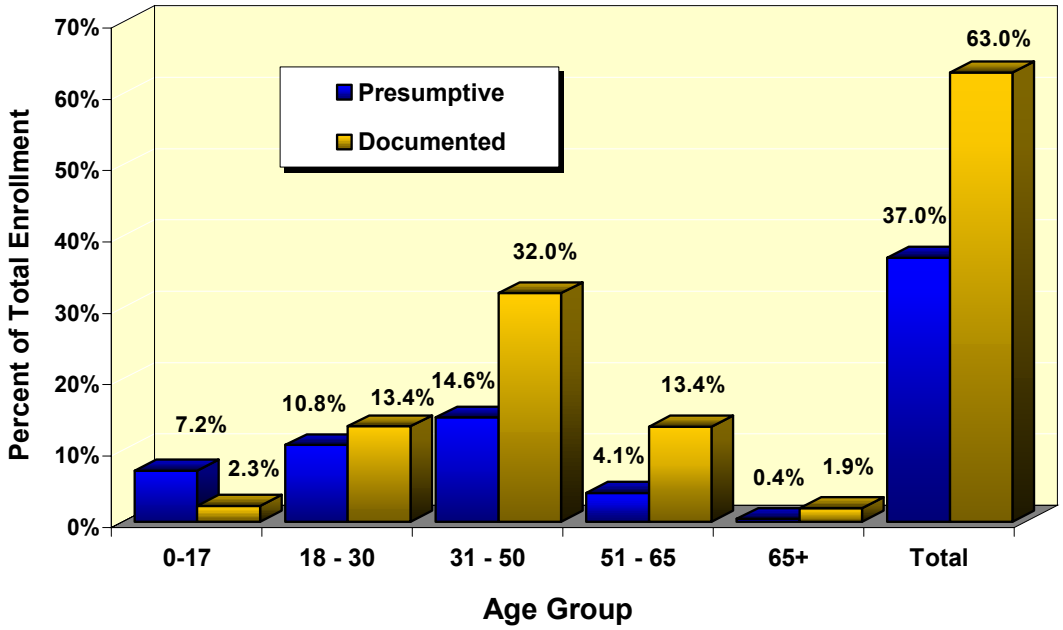
- The PE enrollees make up 28 percent of the overall Alliance population
- The distribution of PE male and female enrollees was nearly the same as observed in the documented enrollees (Chart 9.1)
- The largest percentage of PE enrollees were between 31and 50 years of age (Chart 9.2)
- In the 0 to 17 year old category, PE members outnumber the documented enrollees by three to one. This is likely due to those children awaiting enrollment in Medicaid programs
- Wards 1, 7, and 8 had the largest number of PE enrollees
- Ward 8 had nearly as many PE enrollees as documented members.

Chart 9.1



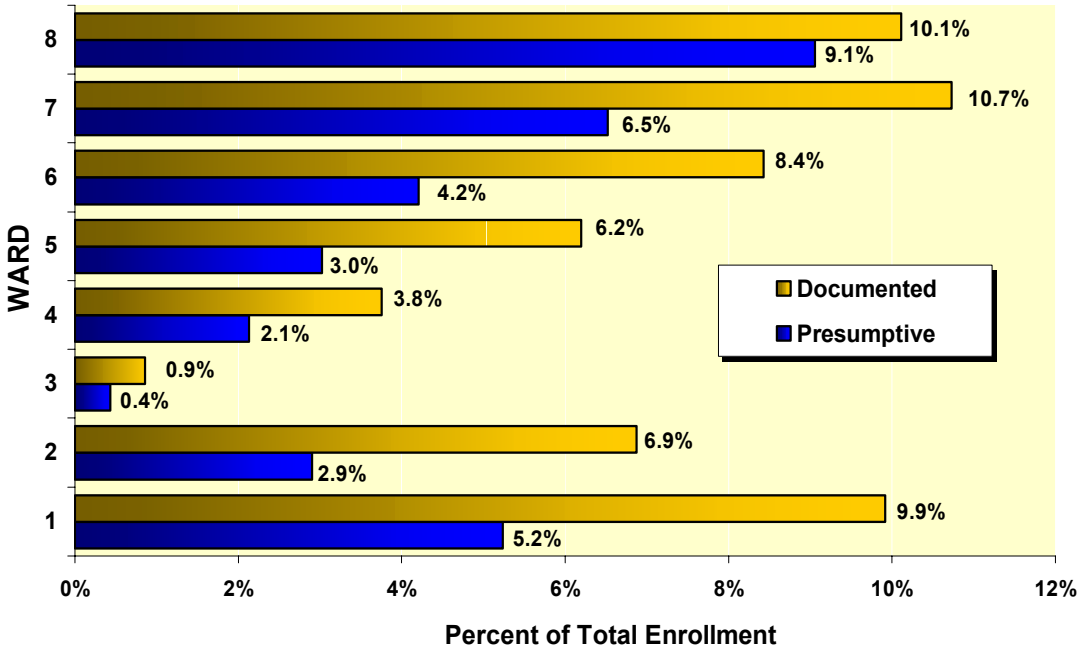
Source: CHP and Member Database Time Period 06/01/01 through 05/31/02 for claims paid as of October 2002.

Chart 9.2 **Alliance Enrollees by Age and Enrollment Status**
Presumptive vs. Documented



Source: CHP and Member Database Time Period 06/01/01 through 05/31/02 for claims paid as of October 2002.

Chart 9.3 **Alliance Enrollees by Ward and Enrollment Status**
Presumptive vs. Documented



Source: CHP and Member Database Time Period 06/01/01 through 05/31/02 for claims paid as of October 2002.

The most frequently occurring disease categories in the Alliance population are shown in Table 9.1. These vary according to service category and gender, as well as enrollment status.

By comparing the general Alliance populations, the presumptively eligible enrollees, and the documented enrollees, top three disease profiles by claim type reveals:

- Hypertension was among the top three disease conditions across all categories of enrollment
- Dental disorders were prevalent across all populations
- Ambulatory disease conditions such as cocaine abuse, acute pharyngitis, and UTI appeared to be more prevalent in the PE population
- The greater prevalence of child medical examinations in the PE population is likely related to children that are receiving care under the Alliance while awaiting enrollment into Medicaid programs.

Healthy People 2010 Categories and Alliance Disease Prevalence

The most significant disease distinctions between the presumptive and documented enrollees are demonstrated in the chronic illness groups that are identified in the Healthy People 2010 disease categories. A review of these disease categories for both the presumptively eligible and the documented enrollees reveal:

- Hypertension, diabetes, and dental conditions present as appreciably more prevalent in both populations; however, the PE members receive significantly more services per enrollee for treatment of these conditions
- The prevalence of hypertension in PE females was considerable
- The difference between PE and documented enrollee rates of diabetes and hypertension was remarkably high
- Overall, the PE population appears to be sicker and receive more care for their illnesses. Follow-up with these enrollees is important to determine if they actively seek enrollment by documenting their eligibility, or were enrolled in another program.

Table 9.1 Top Three Diseases By Enrollment Status, Service Category and Gender

Service Group	All Alliance Enrollees		Presumptive Enrollees		Documented Enrollees	
	Male	Female	Male	Female	Male	Female
All Services	Hypertension Diabetes Dental Caries	Hypertension Up.Resp.Infect. Rx refills	Dental Pulpitis Hypertension Medical Exam	Pregnancy Hypertension Dental Pulpitis	Hypertension Dental Caries Dental Pulpitis	Hypertension Pregnancy Dental Caries
Inpatient Services	Hypertension Abnormal EKG Pneumonia	Hypertension Abnormal EKG Pneumonia	Hypertension Pneumonia Cocaine Abuse	Hypertension Pneumonia UTI	Hypertension CHF Abnormal EKG	Hypertension Anemia Abnormal EKG
Physician Services	Hypertension Diabetes Medical Exam	Hypertension Diabetes Medical Exam	Hypertension Med. Exam – Child Chest Pain	Pregnancy Hypertension Med. Exam – Child	Hypertension Diabetes Medical Exam	Pregnancy Hypertension GYN Exam
Emergency Services	Rx Refill Hypertension Abdominal Pain	Hypertension Abdominal Pain Rx Refill	Rx Refill Hypertension Abdominal Pain	Abdominal Pain Acute Pharyngitis UTI	Rx Refill Hypertension Convulsions	Hypertension Abdominal Pain Rx Refill

Note: Ranked in order from most common to least common.
Source: HCSNA DW, claims data June 2001 to May 31, 2002 for claims paid through August 2002.

Health Services Utilization

The presumptively eligible population had the lowest level of health service utilization when compared with documented enrollees and the DCG population (see Section VIII Alliance Health Care Services and Member Utilization).

The utilization rates depicted in the following charts (utilization per 1000 enrollees) is a measure of the number of times a diagnostic code was encountered in the claims data. This is a gross measure of prevalence of a condition, but is not a measure of the number of individual patients with the condition. The significance of outpatient workload will outweigh inpatient workload in overall measures and should be considered when evaluating the results.

Chart 9.4A Healthy People 2010 Disease Categories for Male Enrollees
Presumptive vs. Documented

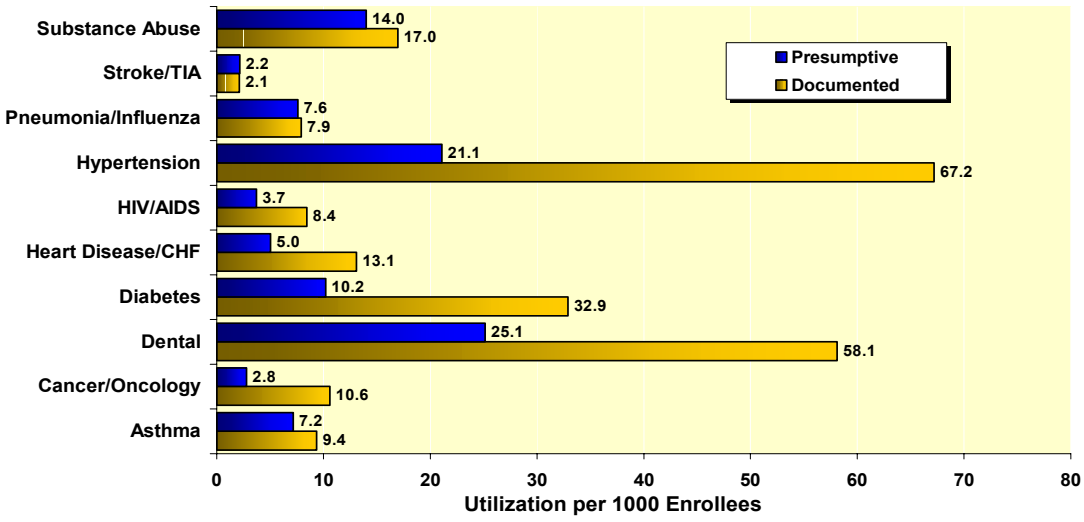
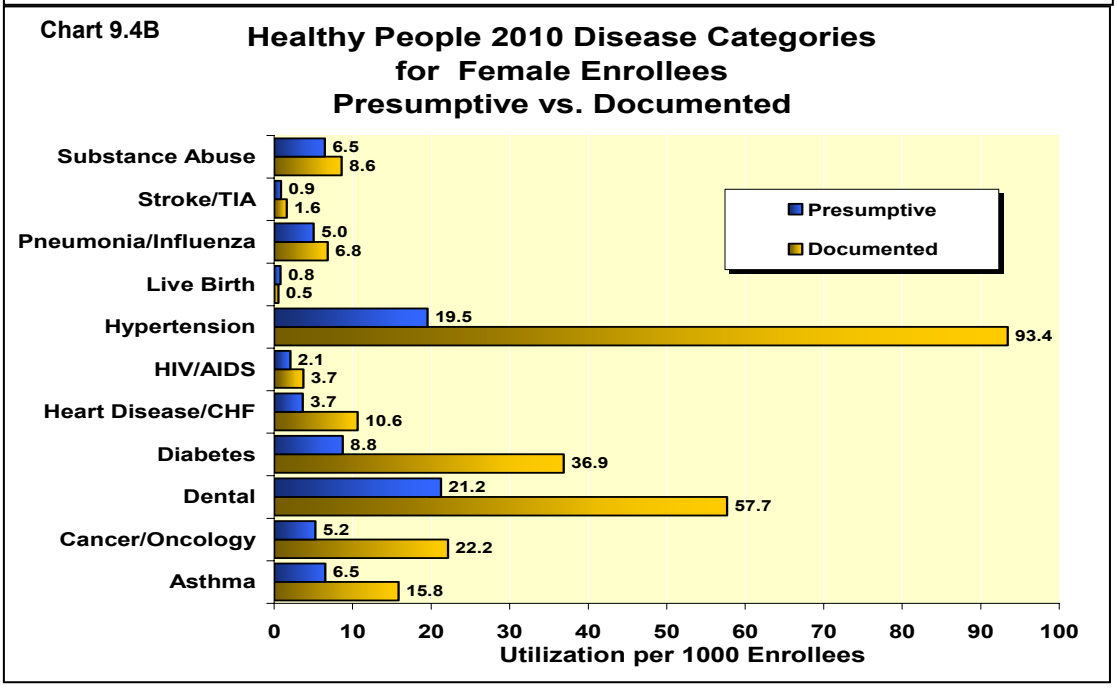


Chart 9.4B Healthy People 2010 Disease Categories for Female Enrollees
Presumptive vs. Documented



Source: CHP and Member Database Time Period 06/01/01 through 05/31/02 for claims

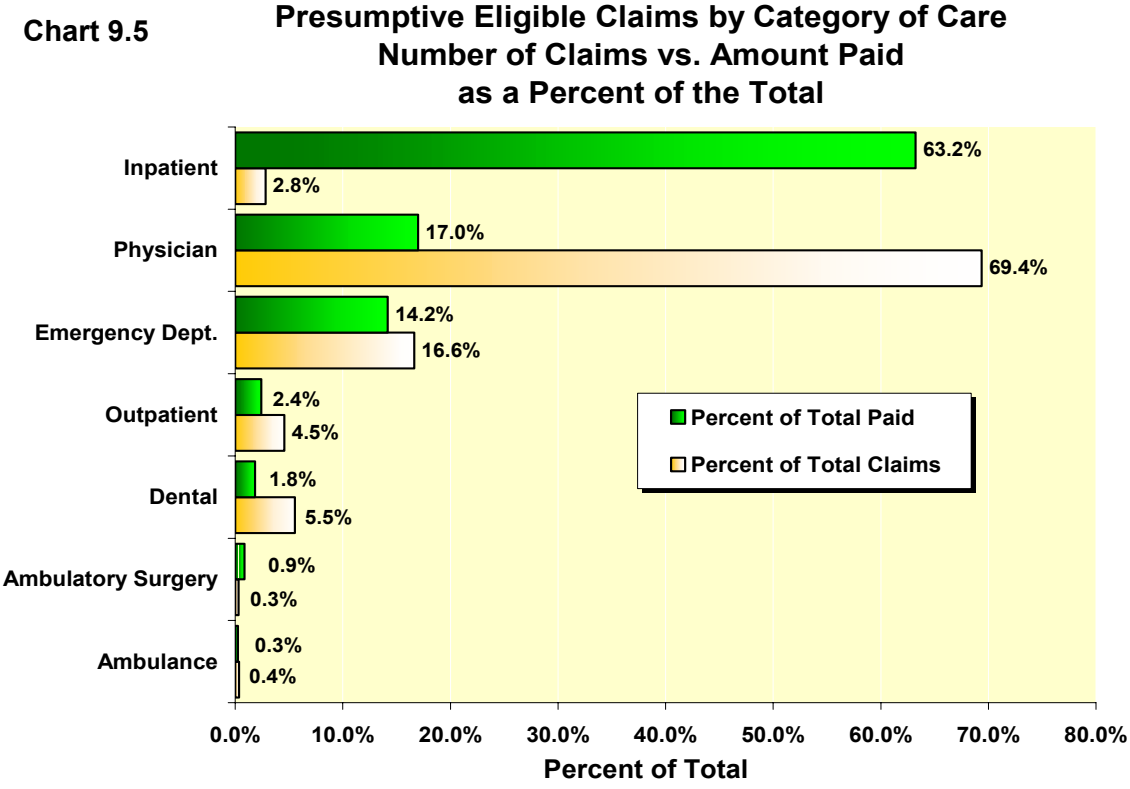
Overall Presumptive Enrollee Service Utilization

The paid services used by PE members were categorized according to the following service types: inpatient, outpatient, emergency department, physician, dental, ambulatory surgery, durable medical equipment, ambulance, home care, and skilled nursing care. Chart 9.5 illustrates all paid PE services, from all claims data, provided from June 2001 to May 31, 2002 made in the first year of operation.

The 12,448 claims were received for 4,615 distinct Alliance members with services, resulting in an average of 2.7 claims per member.

The proportion of total claims volume for physician services was nearly 70 percent, while the proportion of the amount paid for physician services was only 17 percent of the total cost of services. This relationship was the reverse for inpatient services provided to PE enrollees. Here, the proportion of inpatient claims volume was less than 3 percent, while the proportion of overall claims paid for the inpatient services was 63 percent of the claims payment for PE enrollees, during the first year of operations. This relationship reflects the higher cost per unit of service of inpatient versus outpatient care.

Chart 9.5



Note: Home Care, Skilled Nursing Facility, Pharmacy and Durable Medical Equipment each had less than 0.3% of total claims and amount paid.

Source: CHP and Member Database Time Period 06/01/01 through 05/31/02 for claims paid as of October 2002.

When the PE enrollee utilization is compared with the overall Alliance utilization for the first year, the differences are remarkable.[1] Significant differences occur in the service areas of outpatient, inpatient, emergency department, physician and dental care:

- **Outpatient**: The Alliance population had twice as many outpatient services that made up their total claims volume than the PE group, but OP costs made up nearly three times more of their overall paid services.
- **Inpatient:** The PE group had a greater proportion of inpatient services making up their total claims volume than did the Alliance population. Furthermore, inpatient services made up 14 percent more of their overall paid claims.
- **Emergency:** The PE group had a greater proportion of emergency department services making up their total claims volume than the Alliance population, and it represented a greater percentage of their overall paid services.
- **Physician:** The relative proportion of services represented by physician visits was nearly equal for PE and Alliance populations. However, a greater proportion of Alliance physician visits were represented by paid claims.
- **Dental:** A greater proportion of the Alliance enrollee's visits were for dental services than observed in the PE group. The proportion of the total amount paid for services for dental care was greater as well. The types of dental services used by the PE population are similar to the overall Alliance population as illustrated in Chart 9.6.

These findings are consistent with the disease/service utilization and Healthy People 2010 disease indicators for the PE enrollees. It appears that, by service category, the PE enrollees tend to rely on emergency and inpatient services more than fully enrolled members. They appear to be seeking physician services at a similar rate but are likely to be using less specialized or preventative type care.[2] Outpatient (diagnostic) and dental services also made up a smaller percentage of the care the PE enrollees received. This is likely to be the reason for a greater dependence on inpatient and emergency services by the PE enrollees. A review of the use of pharmacy and laboratory services by enrollment group should follow a similar pattern.

Focusing on inpatient services shows the PE enrollees used fewer inpatient services than the overall Alliance population, even though they depended on it more for care. Less was spent for inpatient claims, and there were fewer discharges per PE enrollee. In addition, the cost per PE discharge was less than for that of the overall Alliance population. This information is provided in Table 9.3.
Although we do not have these services broken out by month, the trend for cost and utilization of inpatient claims in the last 6 months was on the rise as compared to the first 6 months. This trend will warrant monitoring in the months to come.

[1] Please note that the laboratory values are removed from this depiction as they are not distinguished by use for presumptively eligible, only for the total Alliance population, thus comparisons are not possible.

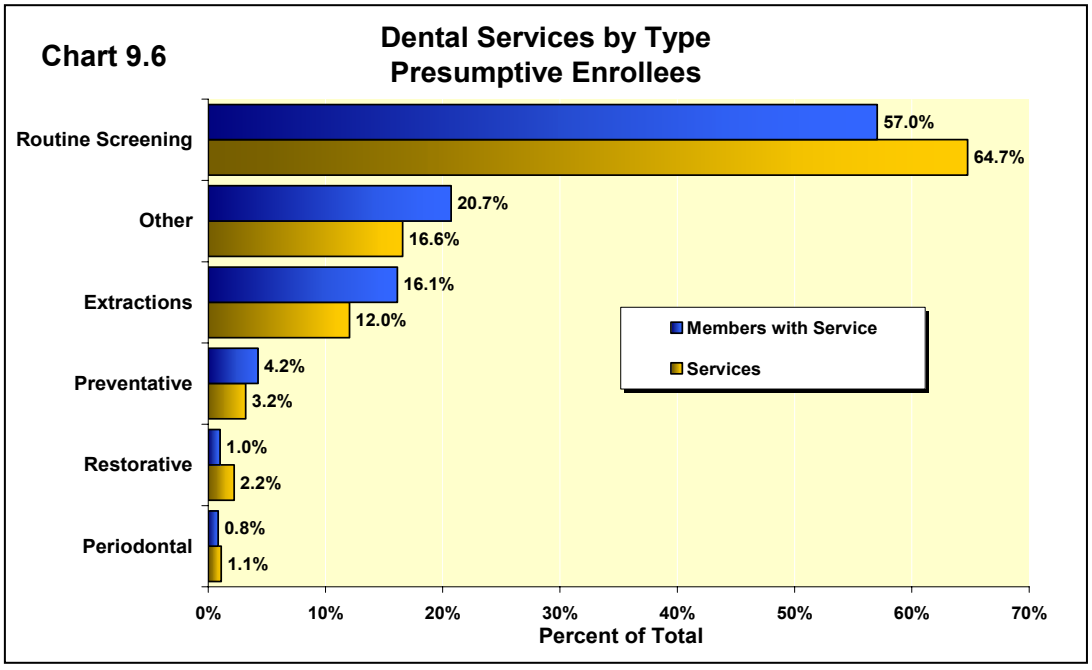
[2] This analysis assumes that specialized care cost more and preventative services cost less than the average physician visit.

Table 9.2 Comparison of Overall Health Services Utilization	
Presumptive Eligible	**Documented Eligible**
Enrollment totaled 10,406	Enrollment totaled 27,208
4,615 of the PE enrollees received health services	17,064 of the 27,208 enrollees received health services
The health service utilization rate was 44%	The health service utilization rate was 63%

Source: CHP and Member Database Time Period June 1, 2001 through May 31, 2002 for claims paid as of October 2002.

Table 9.3 Comparison of Inpatient Service Utilization	
Presumptively Eligible	**Total Alliance Enrollees**
Number of inpatient discharges: 350	Number of inpatient discharges: 2,128
Total amount paid for inpatient claims: $2,680,592	Total amount paid for inpatient claims: $16,659,687
Discharges per 1000 PE enrollees: 34	Discharges per 1000 Alliance enrollees: 56
$7,659 per discharge	$7,829 per discharge

Source: CHP and Member Database Time Period June 1, 2001 through May 31, 2001 for claims paid as of October 2002.



Source: CHP and Member Database Time Period 06/01/01 through 05/31/02 for claims paid as of October 2002.

Recommendations for Next Steps

The findings presented in this section suggest the following comparisons between the presumptive enrollees and the documented enrollees:

- Population demographics appeared to be similar
- PE enrollees seemed to have a greater percentage of acute conditions and conditions treatable with ambulatory procedures than the documented enrollees
- PE enrollees seemed to have greater proportion of substance abuse diagnoses
- Documented enrollees seemed to have a greater prevalence of chronic diseases as categorized in the Healthy People 2010 groupings
- Overall, the proportion of service use was higher in the PE group for inpatient and emergency department care.

A continued policy of presumptive eligibility enrollment for the Alliance will require careful monitoring for rising costs on a monthly basis. The data trends for the first year suggest that the overall costs will rise with this population. Appropriate program enrollment and referrals for out of coverage benefits will be critical in maintaining costs. In addition, educational and clinical management of this group will be vital to limiting unnecessary use, monitoring care, and changing the healthcare utilization patterns of this population.